DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY DAY, D. SUMMARY STATEMENT OF DEFICIENCIES OR CARMEL IN 48032 STREET ADDRESS, CITY, STATE, ZIP CODE 119 MEDICAL DR CARMEL IN 48032 STREET ADDRESS, CITY, STATE, ZIP CODE 119 MEDICAL DR CARMEL IN 48032 GROSS REFERENCED TO THE APPROPRIATE DEPOLATION OF CORPORATION OF COMMUNITY TAG. (F 000) INITIAL COMMENTS (F 000) INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00163721, completed on February 3, 2015. This visit was for on Junction with a Post Survey Revisit (PSR) to the Investigation of Complaints IN00162089 and IN00162358, completed on January, 22, 2015. Complaint IN00163721: corrected Survey dates: February 24, 25 & 26, 2015 Facility Number: 000095 Provider Number: 105298 AM Number: 100290490 Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF: 23 SNF:NF: 124 Total: 147 Census Payor Type: Medicare: 24 Medicare: 34 Medic	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		155181	B. WING _			R-C	
NAME OF PI	ROVIDER OR SUPPLIER	100101		STREET ADDRESS, CITY, STATE, ZIP (CODE	02/26/2015	
CARMEL	HEALTH & LIVING COMM	MUNITY		118 MEDICAL DR			
				CARMEL, IN 46032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE			
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